PRINCE EDWARD ISLAND

OUT-OF-PROVINCE LIAISON PROJECT REPORT

P.E.I. HOSPITAL AND HEALTH SERVICES COMMISSION

March, 1989

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TO ALL READERS

The Prince Edward Island Hospital and Health Services Commission is pleased to present this report on the Out-of-Province Liaison Project.

The report reflects the general views of a large number of persons in the Health Care field on Prince Edward Island and off Prince Edward Island. It does not officially represent the opinions of organizations or institutions mentioned.

The Prince Edward Island Hospital and Health Services Commission greatly appreciates the cooperation expressed by all those who participated in the project. This cooperation has assisted in developing a basis for recommendations to create a Liaison Program.

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EXECUTIVE SUMMARY

The P.E.I. Hospital and Health Services Commission has recognized for some time, a need to establish a strategy for the effective management of the usage of out-of-province health care services by Island residents. While it was recognized that P.E.I. is unable to provide various specialized treatments within the province and some residents must seek these services elsewhere, concern was raised about the increasing expenditures in this area.

A Commission document in 1987, "New Directions for Management of the Health Care System" clearly identified the need for planned strategies to manage the Provincial Health Care System effectively and efficiently.

It was obvious that the current situation relative to out-of-province usage would have to be determined before planning could begin for the future. Upon examination of Commission records, it was revealed that approximately fifty-two Islanders were in hospital outside the province each day. In consideration of a total population of 128,900, this represents a substantial segment of the patient population. Further to this, it was noted that other than the fact that prior approval was required from the Commission for payment of treatment and services outside the province, little else was known about the condition of or circumstances surrounding these patients. It was unclear as to whether these patients had particular needs before, during, and after hospitalization.

Questions were raised such as:

- Could some patients be returned to Prince Edward Island for the latter part of their hospitalization? If so, what were the obstacles to this concept?

- Would this be an acceptable idea to out-of-province hospitals, Island hospitals and physicians?

- Does P.E.I. have the support system required to provide a continuation of services?

- Is it cost effective to consider payment by the P.E.I. Commission of the patient's portion of the transportation costs to finish hospitalization in an active treatment centre back on P.E.I.?

- Does P.E.I. need a program that can maintain an informed linkage with out-of-province services?

- Is there a responsibility on the part of P.E.I. to provide supports other than the payment of the service to Islanders who must seek health care elsewhere? Of consideration here is the undoubtedly extra costs incurred by patients while outside the province.

Indeed, the Commission continues to be grateful for the provision of services to residents of Prince Edward Island by out-of-province hospitals. However, in view of escalating costs it appeared reasonable to investigate some of the concerns raised without creating disorder in the health care system.

Based on the questions raised, a project to gain an insight into the overall situation was started in mid-1988 with a plan to make recommendations for a Liaison Program. The project evolved into a three part endeavour including accumulation of more data, solicitation of advice and input from health care providers, and a pilot to substantiate concerns raised.

The data revealed concentrations of patients and services provided. It was found that Halifax, Nova Scotia, and the Moncton Hospital in New Brunswick had the largest number of P.E.I. residents as patients.

Advice and input were solicited from hospital personnel in Halifax and Moncton as well as all hospitals, Home Care Programs, some physicians, and volunteer agencies on P.E.I. From the interviews it was determined that there was a need for better communication lines.

Finally, a two-month Pilot Project was implemented with four Halifax Hospitals to obtain a "working knowledge" of the discharge planning process in each hospital and to test the feasibility of transfer of patients back to home hospital.

The pilot was successful in that it provided some substantiation to issues raised during the interviews and a starting point towards developing a liaison. It also encouraged thirteen inter-hospital transfers and four Home Care referrals back to P.E.I. for a total out-of-province saving of 241 hospital days.

One of the most significant problems was the vast number of services and personnel involved and the mere fact that in health

care nothing is ever black and white. A gradual communication link was developed from the experiments of the pilot.

As an interim measure, until the recommendations of the report are accepted, the transportation payments are continuing with all out-of-province hospitals.

Staff on both sides are referring problems to the Liaison Coordinator for resolution or facilitation. Negative feedback has been minimal. It must be understood that although much knowledge was gained, there is still much to learn.

This report and recommendations are the culmination of the findings during the period of the project. The resulting recommendations show that a liaison program is a valuable tool for the P.E.I. Hospital and Health Services Commission to better understand and manage the use of out-of-province services. Through this program, trends can also be monitored that can help to identify areas for strategic planning of the future.

The P.E.I. Hospital and Health Services Commission gratefully thanks all those who played a part in the project for their patience and cooperation, and it is hoped that the relationships that have developed will continue.

TERMINOLOGY

For the purpose of this report the following terms are used:

PATIENT - refers to a Prince Edward Island resident in hospital outside the Province.

COMMISSION - P.E.I. Hospital and Health Services Commission

OUT-OF-PROVINCE - Hospitals and/or Health Care Institutions providing services to a P.E.I. resident outside of Prince Edward Island.

P.E.I. LIAISON - P.E.I. Hospital and Health Services Commission representative and project coordinator.

INTRODUCTION

In June, 1988, the P.E.I. Hospital and Health Services Commission embarked on a six-month project to begin a liaison with out-of-province hospitals providing services to Island residents.

The object of the project was to examine the concept of returning P.E.I. residents back to their home hospitals or communities as soon as their state of health warranted and to identify issues and concerns surrounding such an endeavour. At the same time, active involvement was to start towards encouraging earlier patient discharge back to P.E.I. when and where appropriate. The process was to begin gradually and to be built on experience, thus evolving a structure that would best meet the needs of all parties.

1.1 TERMS OF REFERENCE FOR THE PROJECT

1. Study problems and issues relating to Out-of-Province hospital usage.

2. Report findings to management of the Commission.

3. Develop policies to address identified issues regarding Out-of-Province patients for Commission approval.

4. Establish a beginning effective liaison with major Out-of-Province hospitals used by Island residents.

5. Explore services and facilities on the Island indicating obstacles to safe and efficient discharge planning.

6. Present a report including proposed recommendations for the development of a comprehensive liaison program between P.E.I. and Out-of-Province hospitals.

1.2 THE PURPOSE OF THIS REPORT IS:

- To identify the issues relating to out-of-province hospital usage.

- To document the developmental progress of the project over the six month period.

- To provide recommendations for the implementation of a liaison program with out-of-province hospitals.

1.3 METHODOLOGY

It is understood that services provided to Islanders are not all performed in hospital. However, as a starting point, it was deemed wise to place the emphasis on in-hospital patients for this time period.

The project involved three components that resulted in the recommendations submitted:

Accumulation of Data - Existing data within the Commission and from out-of-province hospital admission lists was accumulated to determine numbers and types of diseases of P.E.I. patients receiving treatment outside the province.

A series of interviews and meetings was held with a wide representation of the health care sector on P.E.I. and with personnel from out-of-province hospitals to identify issues and concerns involving out-of-province patient usage.

A Pilot Study Project was undertaken with four Halifax hospitals to determine the best method of addressing the issues for beginning a liaison and to gain a "working knowledge" for the development of recommendations.

2. OUT-OF-PROVINCE PATIENT DATA

2.1 OBJECTIVE

To provide an overview of the highest concentration of P.E.I. patients according to unit and/or specialty within the out-of-province hospitals.

2.2 PROCESS

In early 1988, a five year comparison of out-of-province costs, patient admissions and average length of stay for in-patients had been calculated. The result showed that in 1986-87 approximately 52 Islanders per day were in hospital out of province. The majority were in the Halifax area at the Izaak Walton Killam, Halifax Infirmary, and Victoria General Hospital averaging approximately 37 per day. A substantial 6-8 others were in Moncton with the remainder scattered throughout the rest of Canada and elsewhere.

An attempt was made to identify specialty areas in each of the hospitals most frequently admitting Islanders. It was felt this would provide a starting point for beginning a liaison.

Statistical data on in-hospital admissions was gleaned from a number of sources including Commission reciprocal billing records, post-admission notices, and individual out-of-province hospital admission files. The data reviewed at the Commission was not adequate enough to show actual units or services

frequented within hospitals. A spot check of prior approval records on ten patients admitted by the end of June 1988 to the Victoria General indicated that only one-half had prior approval records for treatment outside P.E.I. It was obvious this source of information would not be useful either.

Therefore, based on interviews with Admitting and Nursing Departments of hospitals and whatever data could be supplied, a rough picture was presented on in-hospital P.E.I. patients outside the province.

2.3 DATA INFORMATION, HALIFAX, NOVA SCOTIA

IZAAK WALTON KILLAM HOSPITAL - This hospital admits patients to units not necessarily according to service but on a combination basis of age and type of condition. Numbers were calculated from admission and separation records indicating the Unit to which a patient had been admitted. There were 297 admissions of Island children for 2405 days stay during the fiscal year of 1987-88. It was determined that the units of 8-west (Neonatal) and 5-East had the largest representation of patients. The units of 5-South and 4-West were also greatly used. Generally speaking, Head Nurses take an active role in discharge planning with counselling and financial advisement performed by the Social Work Department. The Home Care Program is managed directly through the Izaak Walton Killam Hospital Home Care Program while referrals for public health services are

channeled via the Community Liaison Nurse. Most of the latter's referrals are primarily supervisory in nature as parents are usually taught their child's care before discharge. Transfers to P.E.I. directly from the Neonatal Unit are not frequent because of the high cost to parents. If transfers do take place, the Neo-Natal Unit staff prefer transfer to the Queen Elizabeth Hospital Neo-Natal or Pediatric Unit. Generally speaking, infants remain at the Izaak Walton Killam Hospital until they are ready to go home.

HALIFAX INFIRMARY - Information for this facility was calculated from Commission reciprocal billing data for the fiscal year 1987-88. Out of 210 patients admitted to the Halifax Infirmary for 2059 days of stay, approximately ninety were admitted for gastrointestinal problems. Forty-five patients had Opthalmic disorders and thirty were under the Ear, Nose, and Throat service. The remainder had varying disorders.

Discharge planning for patients is coordinated by the Head Nurse of the Unit with involvement by the Social Work Department. A Community Liaison Worker under the Social Work Department has done extensive work in compiling a resource guide for use on the Units.

VICTORIA GENERAL HOSPITAL - Computerized data from this hospital presented a more in-depth picture of numbers of patients per service and unit. The highest numbers of P.E.I. residents at this facility, for the 1987-88 fiscal year, were found in the following services:

Cardiology -53, Cardiac Catherization - 115, Cardiovascular Surgery - 54, Gynecology - 34, Neurosurgery - 53, and Urology - 79.

The total number of in-patient admissions was 570 with the number of Day Surgery, Ambulatory Care, and in-patients totalling 937 people.

TABLE I

A computerized Executive Summary for the calendar year of 1987 itemized the following for P.E.I. inpatients at the Victoria General:

Number of admissions - 549
Number of Deaths - 11
Number of Discharges - 538
Total length of stay - 6233 days
Average length of stay - 11.4 days
Average per day - 17.4

Discharges		%
To Home/Self Care	- 508	94.4
To Home Hosp.	- 22	4.1
To Home Health Serv.	- 6	1.1
Against Advice	- 2	0.4
	538	100

It is apparent that the majority of patients stay in hospital out of province until they can be discharged home under their own care with a significantly low percentage discharged to home hospital or Home Care.

In this hospital, the Head Nurse remains the key contact for patient care; however, the discharge responsibilities are divided between various departments such as the Primary Care Nurse, Social Work Department, V.O.N. Liaison Nurse, and Discharge Monitoring. Discharge Monitoring has the overall responsibility of monitoring and ensuring continuation of the discharge process.

Referrals for planning are directed according to the health status and requirements of the patient. For example - Social Work plans for discharge to the community with home supports, Discharge Monitoring arranges inter-hospital, nursing home, and Ambulance/Air Transfers while the V.O.N. makes provision for home nursing needs.

With respect to the Home Dialysis Program operated by the Victoria General, patient management after discharge is controlled by this hospital, particularly for continuous cycle peritoneal dialysis, continuous ambulatory peritoneal dialysis and hemodialysis. The cost of home care supplies is funded by the P.E.I. Commission with payment through the Queen Elizabeth Hospital and Prince County Hospitals. Contact with service providers on P.E.I. other than for financial approval is generally limited to the patient's family physician.

For the eight month period between January, 1988 - August, 1988 there were 412 admissions to the Victoria General with 21 discharges to home hospitals.

CANCER FOUNDATION - Although the Cancer Foundation is located in the Dixon Building of the Victoria General Hospital it operates as a separate institution. All patients are treated as out-patients even though they may be an in-patient at another facility. Numbers of Islanders treated in 1987 were 236 patients for 610 forms of treatment. The Cancer Foundation is a big user of the Point Pleasant Lodge.

Hospitals in the Halifax area that provide services to P.E.Islanders but not in large numbers were also assessed for patient concentrations to provide an overall picture for this area.

The **GRACE MATERNITY** had a total of 53 patients for 820 days from December 1987 - November, 1988. This includes both mothers and infants. Eight neo-nates each spent more than 30 days in the facility and three others in excess of 60 days.

The **HALIFAX CIVIC HOSPITAL** is closely associated with the Victoria General. Patients can have day surgery or investigative tests at the Victoria General and then return to the Civic to recuperate.

Only 22 admissions were recorded at the **CAMPHILL HOSPITAL** in the twelve months between September, 1987 - September, 1988 for 244 days stay.

At the **NOVA SCOTIA REHABILITATION CENTRE** the Director of Nursing indicated that she could not recall a patient from P.E.I. in over two years.

Patients averaging 6-8 a day in the **MONCTON HOSPITAL** were primarily admitted to the Neurosurgery Department.

Most of the remaining 6-7 patients were at the **PRINCESS MARGARET**, Toronto, with a few scattered elsewhere.

2.4 OVERVIEW

Based on this overview presented, Prince Edward Islanders were most frequently found as patients in the Neo-Natal Units of the Izaak Walton Killam and Grace Maternity Hospitals. There was a large number in the Gastrointestinal, ENT and Opthalmic Services at the Halifax Infirmary. Cardiovascular/Cardiology, Urology, and Neurosurgery Departments at the Victoria General Hospital also had the most P.E.I. patients. Children other than neo-nates admitted to the Izaak Walton Killam Hospital were in highest concentration on 5-East, 5-South, and 4-West.

Other than the Halifax, Nova Scotia area, the next largest concentration of P.E.I. patients out of province was in the Moncton Hospital. The Neuro-surgical Department has the majority of patients. Most accident and emergency situations, particularly head and back injuries, are transferred from P.E.I. to the Moncton Hospital.

3. INTERVIEWS AND MEETINGS

3.1 OBJECTIVE

To identify issues and concerns of health care personnel involving transfers of patients back to P.E.I. from out of province.

3.2 PROCESS

Input and advice for a Liaison Program was sought from Hospital Administrators, Directors of Nursing, Physicians, Ambulance Operators, Home Care Coordinators, Volunteer Health Care Agencies and Commission staff on P.E.I.

Representatives of administration and various departments within Halifax Hospitals and the Moncton Hospital were also interviewed. Participants were asked if they viewed problems with the discharge of a patient as an inter-hospital transfer back to P.E.I. Information was solicited with respect to obstacles to discharge planning and knowledge of P.E.I.'s capabilities and services.

The purpose of these introductory meetings was to:

1. Explain the object of the Liaison Project

2. Solicit feedback for suggestions for operation.

3. Determine issues and concerns relating to out-of-province usage.

4. Determine an understanding for the current and past situation with patients coming back from out of province.

5. Gain cooperation in working towards facilitating an improved system.

The format was varied ranging from informal interviews and telephone conversations to presentations at scheduled staff meetings with minutes taken.

3.3 PRESENT SITUATION ON PATIENT TRANSFERS FROM OUT OF PROVINCE

The concept of promoting earlier and safe discharge from out-of-province hospitals back to P.E.I. hospitals, Home Care and the patient's local community was generally well received. Respondents concurred that the project was a worthwhile endeavour of probable benefit to the patient and agreed to cooperate if they became involved.

Administration in out-of-province hospitals were very positive about the initiative to improve services. The prospect was viewed as providing assistance to their facilities for bed utilization and to staff for resource information on discharge planning.

The feedback from community hospitals on P.E.I. indicated that few patients were transferred directly back to these facilities from out of province. Stewart Memorial Hospital could recall only one direct transfer. This was a positive outcome for the patient due to increased family supports. Western Hospital cited two cases requiring long-term and expensive care. Souris and Kings County Hospitals reported few, if any, direct transfers. O'Leary Community Hospital had experienced satisfactory referrals for chemotherapy patients treated on an out-patient basis. They could not recall any direct in-patient transfers.

In essence, a program to bring patients back to community hospitals to convalesce directly from out of province would be a relatively new, although not an unwelcome experience for these hospitals.

The Prince County and Queen Elizabeth Hospitals appeared to receive the majority of transfers with cases from Moncton cited most frequently. These treatment centers felt they could handle most cases coming back from out of province provided they knew a few days in advance of a pending transfer.

The Pediatric and Nursery Unit Head Nurses at Prince County Hospital indicated a desire for more in-service education for staff. In the Nursery it was indicated that difficulty in availability of staff to work in the Nursing Unit impeded the ability of the Unit to provide intensive neo-natal care.

Based on past experiences with out-of-province transfers back to P.E.I., the most common problems expressed were centered around a lack of communication. One hospital noted that it is

not unusual for a physician to formally accept a patient back and then neglect to book a bed. As transfer arrangements cannot take place until the receiving physician books a bed, this impedes the communication process to arrange a transfer. This apparently is a common occurrence everywhere.

There was mixed opinions regarding discharge information coming back with hospital transfers. Some felt interim reports were not adequate while others viewed them to be satisfactory. There was concern expressed about the need to have more information prior to the transfer about the care required for the patient. It was felt that at times, this was inadequate and made it difficult to prepare for patient needs. It was apparent that the information supplied during the initial contact is very important to allow staff time to make adequate preparation.

Presently, if a P.E.I. Hospital transfers a patient out of the province and a nurse attendant is required, that hospital must supply the nurse. If a patient requires a nurse attendant to come back, then the responsibility is still on the P.E.I. hospital to supply the nurse. This causes financial strains and personnel pressures on the hospital. The Queen Elizabeth Hospital expressed difficulty with obtaining nurses to be available for transfers. Some community hospitals had a good working relationship with the local ambulance companies and if a nurse was required for a transfer, the two parties would collaborate to supply one of a number of nurses who worked on call for the ambulances.

Interviews with the Home Care and Support Division revealed a small number of referrals to this Division from out of province. Summerside had approximately twelve referrals from

Halifax and one from Moncton in the past six months. The majority were for supervisory and homemaker services rather than nursing care. Souris Region reported approximately three referrals in two years and O'Leary had only one, which was initiated by the patient himself after he returned home. Montague Home Care and Support indicated satisfaction with several patients coming back with good discharge summaries. In Charlottetown, most home care referrals from out of province are referred to Public Health Nurses first for screening and then are passed on to Home Care and Support. This poses some timing problems as patients requiring home supports may need them as soon as they return rather than by the time a referral works through the system. Public Health Nurses receive all referrals for Post-Cardiac Surgery.

REFERRAL PROCESS

During the interviews, most physicians expressed a need for the Commission to have better control of the referral process. At the present time, there appears to be little adherence to the requirement for prior approval for payment of an out-of-province service. In many instances, patients receive treatment outside the province and return for check-up without the prior knowledge of the Commission and sometimes even the P.E.I. physician. Some professionals indicated that the Gynecological/Oncology Service at the Victoria General tended to keep patients for follow-up treatment needs once they were initially referred.

Upon the return of out-of-province patients to P.E.I., interim reports tend to be inadequate with detailed discharge summaries arriving weeks later, if at all.

It was felt that it was the Commission's responsibility to ensure adherence to the guidelines for prior approvals and to "tighten up" the referral process.

It should be pointed out that for those patients who must go for treatment, there is great appreciation for the cooperation of hospitals and out-of-province physicians to readily admit to their service.

TRANSPORTATION

Most transfers by the P.E.I. ambulance companies are out of the province. There are not many transfers back to P.E.I. The cost, once outside the province, is the responsibility of the patient. The Hospital and Health Services Commission subsidizes the standard in-province rate as far as the ferry and back. There is no policy established for the payment of any out-of-province travel costs for P.E.I. residents.

The rates established by the P.E.I. Ambulance Association and charged to the patient are:

To or from Halifax	-	$ 700 one way
To or from Moncton	-	$ 465 one way

Patients who only stay for an out-patient procedure such as a CT Scan and return to P.E.I. are charged the full fare over plus 50% for the return trip.

Oxygen usage has an extra charge.

Nurse attendants are paid by the P.E.I. Hospitals provided it is a doctor's order.

Ambulance companies indicated that under current regulations, a trained attendant must be on board while transferring patients. Under these circumstances, a Registered Nurse Attendant is only required if there is Intravenous Therapy or medication required en route.

Commercial air travel has a comparative price tag if the patient requires a stretcher which takes up three seats. Prior notification and approval is required by the air lines with specific guidelines for oxygen, attendants, and bracing mechanisms for safety. Salary and return seat for the attendant must be included in the cost with advance purchase of flight tickets. Again, payment is the responsibility of the patient.

There were concerns raised by ambulance companies over the lack of a Provincial out-of-province transportation plan to cover costs of emergency ambulance transport out of the province. It was felt that given the emergency situation and obvious time constraints these companies are unable to ascertain payment by the patient and must act on their own good faith that the bill for transport will be paid.

Most private insurance plans will only pay a percentage of patient transport costs. There are varying degrees of subsidization as well as criteria for payment. For example, some plans provide coverage for an initial treatment only while

others have a limit to the amount of cost funded in a given period of time. There may be payment for emergency transportation to the nearest medical facility but no provision for payment of the cost back in a non-emergency situation.

Patients generally pay the transportation bill first with reimbursement upon submission of the paid invoice.

Clients of Workers Compensation Board, D.V.A., Social Services, and some Automobile Accident Insurance plans have 100% coverage paid directly to the transporting company provided there is a Doctor's order. There are also a few volunteer agencies that provide assistance for travel costs for specific disease conditions.

It must be noted that a Doctor's order for transportation arrangements does not necessarily ensure that the cost will not be charged to the patient. It was apparent that a good number of hospital staff and physicians assumed that a Doctor's order meant the patient does not have to pay.

The percentage of patients in hospital with insurance coverage to pay the full cost of inter-hospital transfers outside of P.E.I. is unknown.

Out-of-Province hospitals were enthusiastic about the prospect of a Liaison Program. Discharge planning is becoming a priority issue as hospitals work towards utilizing resources in the most efficient manner possible and are already encouraging early transfers back to home hospitals.

Certain specialty areas in Halifax seemed to have a realistic understanding of P.E.I.'s capabilities and limitations.

For example, the Izaak Walton Killam Hospital and Grace Neo-natal Unit staff spoke highly of the Queen Elizabeth Hospital neo-natal unit. The Cancer Foundation expressed high regard for the Oncology Services and a physician at the Halifax Infirmary was impressed with the quality of referral information supplied on patients from the Summerside area. Moncton Hospital Neurosurgical Head Nurse made special note of the P.E.I. Rehabilitation Unit.

The general response from staff in Halifax hospitals was "we never have any problems with P.E.I." This was encouraging, however, when questioned there were very few, other than those mentioned, who actually had a good understanding of P.E.I.'s capabilities and limitations. With the exception of the Community Liaison Nurses, most individuals including Physicians and Social Workers, were surprised to learn about the province-wide Home Care and Support Program, Palliative Care Services, and Ambulance Attendant Training Levels.

It was encouraging to note there was a genuine interest to learn more.

Overall, there did not appear to be much experience with the transfer of Islanders back to home hospital. Discharge Monitoring at the Victoria General was able to describe a few cases. A specific obstacle to discharge planning cited by the Grace and Izaak Walton Killam neo-natal units was the high cost of transfer of infants back to home hospitals. Presently, babies stay out of province until well enough to go home in the family automobile. In consideration of mother and infant bonding, this problem is a great impediment.

Feedback from meetings with personnel from the Moncton Hospital indicated a strong commitment towards returning patients to P.E.I. as soon as possible. It is apparent, in view of feedback from P.E.I. hospitals, that this is already a standard procedure for this hospital. Instances were described where patients returned directly from the Neurosurgical Intensive Care Unit. It is believed that patients progress and respond faster in an environment where they can be with the familiar faces of family and friends. At this hospital, staff interviewed exhibited a fairly good knowledge base of P.E.I.'s capabilities. It was noted that there has been a decrease in head injury admissions since Seat Belt Legislation has been enacted in P.E.I.

Although it is not a new idea, generally speaking, it would appear that a program which would encourage the concept of earlier discharge back to P.E.I. Hospitals would be a learning experience for most.

3.4 CONCERNS AND ISSUES ABOUT INCREASED PATIENT TRANSFERS FROM OUT OF PROVINCE

Concerns and issues raised both on and off Island during the interviews about anticipated transfers were of a similar nature. Therefore, they were grouped together under the following headings:

Communication
Transportation
Education
Ripple Effect
Attitude of the Public
Supply Costs
Itinerant Surgery

COMMUNICATION

The major and most frequent concern raised was a need for good communication. Advance notification on pending transfers would allow sufficient time to ensure availability of a bed, to obtain any supplies not readily available, and to provide in-service for staff in the smaller hospitals, if required. As discharge orders are generally written the day before discharge, this allows little time to prepare for a transfer.

There was also a concern for adequate discharge summary information to ensure continuity of care. Physicians and nurses

viewed this as a vital need for transfers to and from P.E.I.

One out-of-province hospital suggested that some communication between transporting ambulances and receiving hospitals during emergency transfers would improve the hospital's ability to prepare for admission.

A number of people suggested that a central office would be beneficial to handle communications for transfers, act as a resource centre and generally be the facilitator for inquiries and concerns. Regardless, the benefits of pre-planning and good communication cannot be underestimated.

TRANSPORTATION

A major issue that is an obstacle to discharge planning for patients returning to home hospital is the cost of transportation and the lack of a policy within P.E.I. to subsidize out-of-province travel costs.

Out-of-province hospitals in Halifax readily admitted that it is unlikely a patient would be discharged by ambulance to home hospital at a cost to that patient if he/she can go home by car a short time later. The Grace Neo-natal and I.W.K. neo-natal cited this obstacle as the greatest deterrent to discharge to the Neo-natal unit at the Queen Elizabeth Hospital.

Staff in out-of-province hospitals frequently commented on an obvious drain on family resources of patients who must seek frequent and prolonged treatment outside P.E.I. Time lost from work, accommodation, ferry and travel expenses, long distance telephone charges, and babysitting costs add greatly to the worries of patients and families. Families with children suffering from long illness were especially noted.

In comparison, other provinces with the exception of Nova Scotia, have out-of-province travel plans. Criteria for payment varies greatly for transportation both to and from each home province. Plans are primarily for in-hospital patients and prior approval is required for payment.

EDUCATION

Community hospitals, particularly Western and Kings County, and Home Care on P.E.I. expressed a desire to have time and access to in-service sessions for procedures to upgrade staff skills. At the Prince County Hospital, head nurses in the Nursery and in Pediatrics expressed the same desire. There appeared to be a willingness on the part of out-of-province staff to provide as much information as possible in these instances.

It is also apparent that services are not used if people don't know about them. There needs to be a method devised that ensures updated information about P.E.I. services to out-of-province staff.

RIPPLE EFFECT

The Queen Elizabeth Hospital appears to be the main hospital experiencing bed shortage problems. Concern was raised about out-of-province transfers influencing already long waiting lists and placing pressure on discharge planning locally. It is interesting to note that the same concern was mentioned by out-of-province hospitals experiencing identical problems when P.E.I. patients are transferred by emergency to them.

It is obvious that an effective program should promote discharge to community hospitals and home care as well as tertiary care facilities.

ATTITUDE OF THE PUBLIC

There is an apparent demand by the public to be treated elsewhere. Feedback from admissions departments in Halifax indicate this situation is not unique to P.E.I.

SUPPLY COSTS

Concern was raised about patients who are discharged to Home Care and required supplies. Cost of these supplies would then be the patient's responsibility rather than the hospital's.

Presently there are only a few approved Home Care Programs that finance the cost of supplies for pediatrics.

Smaller hospitals voiced concern over the availability of special supplies and if time would be available to acquire same before a patient's arrival. Again this is relevant to the timing factor for communicating a pending transfer.

ITINERANT SURGERY

A few physicians expressed a belief that out-of-province physicians may be reluctant to discharge a patient not fully convalescent back to the care of another doctor. Others felt that it was appropriate for a patient to return to the original physician provided there was a discharge summary for continuation of care.

Out-of-province physicians interviewed did not view this as a problem as the final decision rested with them for discharge to home hospital. Specialty areas within the hospital may be more receptive to the idea than others because of the nature of the patient's condition and bed availability.

3.5 OVERVIEW

The interviews pointed out common concerns. The merits of effective communication, pre-planning for education and the provision of resource information are key issues to address for an improved linkage. An obvious obstacle is the cost of transportation for inter-hospital transfers of patients.

4. PILOT STUDY PROJECT

4.1 INTRODUCTION

Based on the accumulated information from data and interviews, it was decided to consider a course of action that would test, address, and gather more information to provide recommendations for an effective liaison program.

It was obvious that to establish guidelines that were workable, while at the same time beginning a liaison, it would be necessary to establish a rapport and gain acceptance of hospital personnel. Therefore, it was decided to operate a pilot program with the permission of four Halifax hospitals. The pilot would be the starting point for building a program.

The purpose of the pilot was to gain an understanding of the best method of dealing with issues and concerns related to P.E.I. out-of-province usage.

4.2 OBJECTIVES OF OUT-OF-PROVINCE LIAISON PROJECT

1. To test the feasibility of a payment subsidy by the Prince Edward Island Hospital and Health Services Commission for transport of out-of-province Prince Edward Island patients back to Island Hospitals to convalesce as soon as their state of health warrants.

2. To determine the best method of administration for the payment of the transportation costs.

3. To study the present communication system for discharge from out-of-province hospitals to Island hospitals and to home.

4. To begin a liaison with out-of-province hospitals which will determine the need for personnel requirements and roles in future programming.

5. To provide information for the development of a system that can identify gaps in services on Prince Edward Island that are obstacles to or hinder discharge planning for out-of-province hospital patients.

4.3 PROCESS

A proposal to the Victoria General Hospital, Izaak Walton Killam Hospital, Halifax Infirmary, and Grace Maternity Hospital Administrations was made to operate a pilot program in designated areas within each hospital for an eight week period from September 12, 1988 - November 2, 1988.

THE ROLE OF THE P.E.I. HOSPITAL AND HEALTH SERVICES COMMISSION WAS:

1. To provide a Prince Edward Island Representative who would document information on a flow chart as per the objectives; and who would act as a resource person. This person was to:

   - Check regularly with admissions departments for Prince Edward Island patients admitted to designated units in Halifax Hospitals.

   - Visit the designated units and inquire on the status of Prince Edward Island patients with respect to discharge planning.

   - Provide resource information on Prince Edward Island capabilities and limitations that assists with discharge planning.

   - If requested and where appropriate, act as a liaison and support for patients and families.

   - Be the contact person for approval of payment of the Commission's transportation subsidy.

   - Negotiate temporary arrangements with hospitals and/or agencies for administration of the payments.

   - Record transportation arrangements of those patients who are transferred back from out-of-province to Prince Edward Island Hospitals including cost of transfer and

payment administration.

- Follow patients after transferred back to Island Hospitals or to home to document follow-up procedures, length of hospital stay and any problems associated with the transfer.

2. To provide a transportation subsidy for the time period of the project, for payment of Prince Edward Island Residents' out-of-province hospital transfer back to P.E.I. hospitals.

3. To arrange with admissions departments for a consent form to be signed by each Prince Edward Island Resident admitted to the designated units for participation in the pilot/study project.

THE ROLE OF THE OUT-OF-PROVINCE HOSPITALS WAS:

1. To designate a unit/specialty within each hospital to participate in this project.

2. To inform the Admissions Department of the need for a signed consent form by Prince Edward Island patients admitted to designated units for participation in the project.

3. To arrange for a meeting with the staff involved and the Prince Edward Island representative to review the objects and methodology.

4. To permit the Prince Edward Island representative to inquire about patient status in order to document discharge planning progress and assist where suitable and appropriate.

5. To encourage the return of Prince Edward Island residents who are candidates for transfer from the designated units to Island hospitals as soon as their state of health is stable, the mode of transport safe, and other conditions are deemed by the attending physician to be conducive to the transfer.

6. Use the Prince Edward Island representative as a resource for information that may be helpful with discharge planning.

The four hospitals approached agreed to participate in the pilot. Arrangements were made for the selection of designated areas in each hospital with Clinical Department Heads and Head Nurses being briefed.

Hospital	Designated Units
Grace Maternity Hospital	Neo-Natal
Halifax Infirmary	G.I. Units, 3A, 3D, 4A, 4C, and 4D
I.W.K.	Neo-Natal (8 West) and 5 East
V.G.H.	5th Floor - Urology and Gyn

A consent form was designed for the patient's signature on admission to the designated unit.

An interim measure was instituted for payment by the Commission for the patient's portion of the cost of a transfer from an out-of-province hospital back to a P.E.I. facility.

A letter of assignment was obtained from Blue Cross of Canada for payment of transfers on behalf of the patient.

A draft transportation form was devised to be used for billing purposes by transport agencies.

The Liaison Project Coordinator was to travel to Halifax for two days each week during the eight week period. In general, the purpose was to gain more knowledge of how systems operate in each hospital.

Calculations to determine the feasibility of payment of the patient's portion of the cost back to P.E.I. were tabulated using the following formula:

Length of stay in P.E.I. up to 30 days X per diem rate out of Province - Cost of Transfer to Commission = Net Dollars Saved.

4.4 OUTCOME OF PILOT

Staff on all units were cooperative and friendly throughout the course of the pilot.

In all, sixty patients from Prince Edward Island were admitted to the designated units over the eight week period. Forty-seven of the patients had signed consents on admission so were used in the study. At the time of this report, one infant transferred back to home hospital in P.E.I. is still an inpatient.

TABLE 1

NUMBER OF PATIENTS ON DESIGNATED UNITS
September 12, 1988- November 4, 1988

Hospital	Consent		No Consent		Total
V.G.H.	18	+	12	=	30
I.W.K.	12	+	1	=	13
Hfx Infirmary	14	+	Ø	=	14
Grace Maternity	3	+	Ø	=	3
	47		13		60

An attempt was made to visit all patients however some were admitted and discharged between the Coordinator's visits.

TABLE II

Number of Study Patients	47 cases
Number of Patients with Private Insurance	16 cases
Number of Patients Transferred to Home Hospital	13 cases
Number of Patients Referred to Home Care	4 cases
Direct assistance provided by P.E.I. for discharge planning	10 cases
Resource information provided only for discharge planning	2 cases
Patient support provided	12 cases
Number of adult patients with no or only one visitor	11 out of 32

FEASIBILITY OF PAYMENT FOR THE PATIENT'S PORTION OF THE COST OF TRANSFER

Thirteen patients admitted to the designated units during the pilot period were transferred back to home hospital in Prince Edward Island. Four others were referred to Home Care and Support.

In all cases patients and/or families voiced pleasure in getting back closer to their homes.

The cost of the transfers to the Commission was approximately $ 6,833 with two transfers paid through a Social Service Program and one paid by a Private Insurance Agency.

Of the total number in the study, sixteen out of the forty-seven patients in the pilot had third party coverage for payment of an inter-hospital transfer back to P.E.I. This represents thirty-four percent with Insurance Coverage.

As indicated in table III, nine patients were hospitalized out of province for longer than 42 days. One patient stayed for 95 days before transfer back to home hospital.

The total length of days stayed back on P.E.I. Hospitals by the transfer patients was 241. Had these patients not been transferred back this number would have to be added to the time the patients had already spent in hospital out of province.

TABLE III

Hospital	Designated Units	L.O.S.	# Pts	Trans. to PEI Hosp.	Ref. to Home Care	L.O.S. PEI
Victoria General	5th Floor Urology & Gynecology	-5 days	4	Ø	Ø	Ø
		+5 days	1	Ø	Ø	Ø
		+10 days	8	1	2	33
		+21 days	2	1	1	19
		+42 days	1	1	Ø	7
		+63 days	2	1	Ø	30+
			18	4	3	89
Halifax Infirmary	GI Service 3A,3D,4A, 4C,4D	-5 days	Ø	Ø	Ø	Ø
		+5 days	4	Ø	Ø	Ø
		+10 days	4	2	1	18
		+21 days	4	Ø	Ø	Ø
		+42 days	1	1	Ø	4
		+63 days	1	1	Ø	13
			14	4	1	45
Izaak Walton Killam	Neonatal - 8 West 5 East	-5 days	2	Ø	Ø	Ø
		+5 days	3	Ø	Ø	Ø
		+10 days	2	Ø	Ø	Ø
		+21 days	3	1	Ø	9
		+42 days	1	Ø	Ø	Ø
		+63 days	1	1	Ø	30+
			12	2	Ø	39
Grace Maternity	Neonatal	-5 days	Ø	Ø	Ø	Ø
		+5 days	2	2	Ø	47
		+10 days	Ø	Ø	Ø	Ø
		+21 days	Ø	Ø	Ø	Ø
		+42 days	1	1	Ø	21
		+63 days	Ø	Ø	Ø	Ø
			3	3	Ø	68

ADMINISTRATION

Approval for payment by the Commission for the patient's portion of the cost of transfer back to home hospital was authorized by the Liaison Coordinator. The person who coordinated the arrangements for transfer was determined at the time of the request for payment. As earlier indicated, at the Victoria General, this procedure is handled by Discharge Monitoring. Elsewhere it was the Head Nurse who made the arrangements. In five inter-hospital transfers and four Home Care referrals the P.E.I. Liaison handled or directed the arrangements.

It was found to be of benefit to obtain approval of payment from third parties prior to the transfer as opposed to after. In these cases, ambulances could send the bill directly to that agency rather than having it held up at the Commission.

There were three babies transferred from the Grace Maternity and two from the Izaak Walton Killam Hospital. Both hospitals were familiar with the Q.E.H. Neo-natal. In all cases a Nurse Attendant was required. For these arrangements it was appropriate for the hospitals to supply and pay the Nurse with reimbursement by the Commission following the transfer. In this way, insurance and liability coverage was maintained. This procedure worked well with adult transfers as well.

Initially, there were problems and confusion over the transportation form. Either it was not being filled out for pick up on the Unit by the transport company or it wasn't being picked up. After a time this became more of a standard procedure with

Ambulance Attendants requesting the form. This form and the bill for transport was then submitted to the Commission for payment.

There was only one client of Blue Cross Insurance. In this instance, the letter of assignment was not sent in by the patient for quite a time. Eventually when it was submitted the Insurance Plan reimbursement was for 100% of the cost.

Generally speaking, the procedure of prior approval for payment, determining third parties before patient discharge and the submission of the transportation form with the bill from the transporting agency worked well.

COMMUNICATION FOR DISCHARGE

More than two months following admission dates, twenty-five of the forty-seven patients on the designated units still did not have approval from the P.E.I. Commission for payment for treatment.

An additional 10 had a record card but no approval for this particular visit. The remaining twelve had approvals for referral for treatment out of province.

It was extremely advantageous to have access to the admitting records of the out-of-province hospitals. Otherwise, there was no way of determining the number of patients actually in hospital out of province.

Based on discussions with head nurses, patients were assessed as possible candidates for transfer back to P.E.I. Further to this, the Head Nurse would approach the attending physician with the suggestion of transfer. If the physician deemed this an appropriate measure, he/she determined when the discharge would be. The attending physician or designate would then contact the receiving physician directly to accept the patient. There were two non-transfer cases where the nursing unit initially were not in favor of transfer to home hospital when suggested, so the physician was not asked. In one other case, the attending physician decided against transfer when asked by the Head Nurse. For those transfers and referrals to home care that did take place the attending physicians were most agreeable to the idea.

It is the responsibility of the receiving physician to book a bed at the local hospital. This proceeded well except in one P.E.I. Hospital where there was confusion over who made arrangements following the physicians initial contact. Subsequently, the hospital circulated a short procedure guide which appears to have clarified roles.

It was obvious that one person should be responsible for transfer arrangements after the physicians have agreed on the transfer. Most times the process went well but in a few that were confusing it was because more than one person was involved in arrangements.

There were four referrals to Home Care. In these cases the Liaison Coordinator was very involved making arrangements. In one case, arrangements for home care dressing changes ordered by the attending physician out of province were overruled in favor

of hospitalization by the P.E.I. physician while the patient was still in the out-of-province hospital.

In the home care cases, contact was made initially by telephone with discharge summaries arriving with the patient or in the mail a short time later. It was obvious that the more time the receiving agency had to prepare for the patient the less problem with arrangements.

An attempt was made to ensure that updated contact numbers and names were supplied to all those involved in referrals. Presentations were made to staff of the Social Work Departments at the Halifax Infirmary and Victoria General, as well as briefing sessions with Nursing Liaison staff.

THE LIAISON'S SUPPORTIVE ROLE

As time progressed, staff, particularly Social Workers, increasingly requested resource information from the Liaison Coordinator. Staff on the units also became used to seeing the P.E.I. name tag.

Patients, particularly those without family near and those experiencing difficulties seemed genuinely appreciative of the P.E.I. visit. In a number of cases, information was supplied which helped them understand the system of a teaching hospital. Eleven of the thirty-two adults reported none or only one family member with them. In one instance, meetings were arranged between the patient's family and staff to clarify confusion about

care. For the most part, patients expressed an appreciation for the good care received but stated a need for emotional support. They also mentioned the high cost of travel and worry about home situations. One lady in poor general health, had picked potatoes for two weeks prior to admission to pay her travel costs to Halifax. Her husband was able to visit her only once during her twenty-two day hospital stay in Halifax.

In another situation, an elderly gentleman's home living arrangements were assessed which helped physicians decide the most appropriate discharge plan for him.

Overall, the Liaison appeared to be beneficial to both staff and patients.

AN INFORMATION SYSTEM TO IDENTIFY TRENDS AND GAPS

It is apparent that correlation of information is important to identify areas that require future development or correction. Obviously if the measure to pay the patient's portion of the transfer costs were to continue there needs to be a system for keeping track of transfers.

Through the experience of the pilot, admission information is now easily accessible from the out-of-province hospitals. The Victoria General Hospital prints a weekly list of P.E.I. residents admitted and discharged and the Halifax Infirmary provides copies of all P.E.I. admission sheets. The Izaak Walton Killam prints a weekly clergy list with patient addresses and the

Grace and Camphill Hospitals notify the Liaison Coordinator when patients are admitted.

This information could be entered on computer at the Commission along with approvals for referral. As numbers are added to the system, P.E.I. should be able to determine disease conditions, costs, and other situations relative to out-of-province usage. In this way, it may prove advantageous for long-range planning in our own Provincial system.

4.5 OVERVIEW

Overall, the initiative to start a liaison by operating a pilot proved successful. In total, 241 hospital out-of-province days were saved for out-of-province.

The patients and families who returned to P.E.I. earlier than anticipated expressed gratitude for shortening their stay out of province. For the most part, patients had their treatments completed and were remaining in hospital because of chronic conditions, complications that had developed, or in the case of infants, needing time to grow.

The learning experience on discharge planning styles of the Halifax hospitals will be useful in determining a role for the Liaison to play in the future. Due to the relationships that have developed, communication lines are more direct and open.

The display of friendliness and willingness to cooperate by staff both on P.E.I. and out of province was most noteworthy.

The P.E.I. Hospital and Health Services Commission is grateful to all those who were involved in the pilot and assisted with the implementation.

CONCLUSION

The Liaison Project to provide an insight into situations relevant to out-of-province patient usage and to investigate the concept of returning patients back to P.E.I. as soon as their state of health warrants was a learning experience of great value.

It was determined that there is a need to have more data available at the Commission which provides current information on patient status out of province. It was also found that returning patients back to P.E.I. was a positive and worthwhile endeavour.

Communication links were started with improved results; however, as with any endeavour involving communication, efforts to maintain linkages must be a continual process.

The pilot was a starting point for a program that should grow and evolve. A Liaison Program should continue, as it would be a beneficial asset to both off Island and P.E.I. Services.

RECOMMENDATIONS

1. That there be an Out-of-Province Liaison Program operating under the Division of Program Support in the P.E.I. Hospital and Health Services Commission. The suggested Terms of Reference would be:

TERMS OF REFERENCE

To be the connecting link between P.E.I. and Out-of-Province health care institutions providing services to P.E.I. residents.

To influence decision making and facilitate the return of patients from out-of-province hospitals back to P.E.I. facilities as soon as their state of health warrants.

To keep abreast of the status of out-of-province patients and investigate long-stay cases.

To be cognizant of programs and situations relative to out-of-province usage by Prince Edward Island.

To be the contact and resource for matters pertaining to out-of-province patients.

To manage the inter-hospital transportation approval system for patients returning to P.E.I. hospitals.

To identify problems in communication links and services and improve situations.

To monitor trends and identify gaps in the system for future program planning.

To represent the Commission as required on matters pertaining to out of province.

2. That the system for liaising with out-of-province hospitals begin with in-patients and then expand to include out-patients, once the program is established.

3. That the referral/approval process within the P.E.I. Commission be managed more efficiently to provide prior notice at the Commission of all patients scheduled for treatment out of province.

4. That all out-of-province information within the Commission be located in one centralized area to monitor trends and for easy access to information on patients out of province.

5. That a process be devised by which Prince Edward Island can investigate long-stay patient records while the patient is still in hospital out of province.

6. That a P.E.I. Hospital and Health Services representative from the Liaison Program be located in the Halifax, Nova Scotia area, to be a contact and resource for hospitals and P.E.I. patients.

7. That discussions begin with the major Halifax hospitals in Nova Scotia to define the role of the representative and to establish a permanent presence in that area.

8. That communication linkages be developed with hospitals servicing Islanders besides those already started to effect and maintain a liaison.

9. That a study of transportation costs for out-of-province inter-hospital transfers take place with a view to establishing a transportation policy that encompasses out-of-province patient transport.

10. That a review of the in-province transportation policy be undertaken so that policies of in-province and of out-of-province transportation are consistent.

11. That the current plan for payment of the in-patients portion of the cost for transfer from out of province to a P.E.I. facility be considered an interim measure until such time as an out-of-province policy is approved.

12. That the Interim measure of payment for the cost of a transfer back to P.E.I. be authorized under the following conditions:

    A. The patient is a resident of P.E.I. and eligible for insured benefits under the P.E.I. Hospital and Diagnostic Services Insurance Act.

    B. The patient is an in-patient in an out-of-province hospital and is to be transferred back to a P.E.I. facility.

C. Anticipated length of stay in a P.E.I. facility is not less than three days.

D. Prior approval has been granted by the P.E.I. Hospital and Health Services Commission.

E. A request form for payment has been submitted along with the invoice by the billing agency with the attending physician's signature (designate) of the discharging hospital indicating the need for the requested means of transport.

F. Only the patient's portion of cost for transport that is not already covered by another insurance or social assistance program will be paid.

G. A registered nurse attendant must be ordered necessary by the attending physician for reimbursement for this nursing service. Reimbursement will be made to the hospital supplying the Nurse.

13. That there be an examination to determine if home care programs managed by out-of-province hospitals can be assisted with supervising client care in Prince Edward Island.

14. That efforts be made to approach a service group to establish and operate a special fund for the financial subsidization of travel costs out of province. This fund

would be for those patients who do not qualify for any other program and are experiencing financial difficulty as a result of an illness and the extra costs of travel out of province for treatment.

APPENDIX A

The following persons were interviewed either in person or by telephone:

Mrs. Marjorie Vessey, Director of Nursing, Queen Elizabeth Hospital

Margo Wallace, Director of Admitting, Queen Elizabeth Hospital

Dr. Kevin Coady, Medical Bed Utilization Committee, Queen Elizabeth Hospital

Dr. A. Muzumdar, Chief of Rehabilitation, Queen Elizabeth Hospital

Dr. V. Kass, Chief of Orthopedics, Queen Elizabeth Hospital

Kay Lewis, A/Director of Nursing, Queen Elizabeth Hospital

Michael Egan, Director of Social Work, Queen Elizabeth Hospital

Judy Dennis, AHN, Unit # 1, Queen Elizabeth Hospital

Jane Edmonds, AHN, Unit # 2, Queen Elizabeth Hospital

Dianne Doyle, AHN, Unit # 3, Queen Elizabeth Hospital

Jean MacPherson, OBS Supervisor, Queen Elizabeth Hospital

Hilda Rossiter, H.N., Unit # 5, Queen Elizabeth Hospital

Marie Savidant, H.N., Unit # 6, Queen Elizabeth Hospital

Gemma Callaghan, AHN Unit # 8, Queen Elizabeth Hospital

Cathy Mutch, Enterotherapist, Queen Elizabeth Hospital

Dr. Dagne Dryer, Oncologist, Charlottetown

Marilyn Lowther, Executive Director, P.E.I. Medical Society

Dr. Ross Stewart, Medical Director, Eric Found Health Centre

Susan Luucks, Executive Director, P.E.I. Cancer Society

Karen Jones, Program Coordinator, P.E.I. Heart Foundation

Gail Kennedy, Executive Director, P.E.I. Hospice Association

Dr. Ellen Wood, Pediatrician, Charlottetown

Janet Rogers, Physiotherapy, Charlottetown

Wayne Carew, Administrator, Prince County Hospital

Barbara Francoeur, Director of Patient Care Services, Prince County Hospital

Melinda Gaudet, Assistant Director of Nursing, Prince County Hospital

Mary Haire, H. Nurse Pediatrics, Prince County Hospital

Nancy MacFadyen, H. Nurse Medical, Prince County Hospital

Donna Walsh, H. Nurse Nursery, Prince County Hospital

Eileen Waite, H. Nurse Obstetrics, Prince County Hospital

Sandra Gallant, Physiotherapy, Prince County Hospital

Eva Kenny, Director of Nursing, Western Hospital

Lester Brennan, Administrator, O'Leary Community Hospital

Wanda MacLeod, Director of Nursing, O'Leary Community Hospital

Mary McGuire, Nursing Department, Stewart Memorial Hospital

Peter Ramsay, Administrator, Souris Hospital

Rosanne Lawlor, Director of Nursing, Souris Hospital

Helene MacFadden, Director of Nursing, Kings County Memorial

Thelma MacLeod, Head Nurse, Kings County Memorial Hospital

Barbara Palmer, Home Care Coordinator, Charlottetown

Paula Collard, Home Care Nursing, O'Leary

John Martin, Home Care Coordinator, O'Leary

Jeannita Bernard, Home Care Coordinator, Summerside

Betty Fraser, Home Care Coordinator, Montague

Pauline Peters, Home Care Coordinator, Souris

Greg Perry, Ambulance Operator, Summerside

Douglas Ferguson, President, P.E.I. Ambulance Association

Neil MacDonald, Ambulance Operator, Charlottetown

Dr. Venora Haldane, Medical Director, Victoria General Hospital

Wanita MacIntyre, Admissions Manager, Victoria General Hospital

Donzela Bruneau, Discharge Planning, Victoria General Hospital

Fran Boutlilier, Medical Admin. Coordinator, Victoria General Hospital

Peggy Gillis, Surgical Admin. Coordinator, Victoria General Hospital

Paul Girard, Director of Social Work, Victoria General Hospital

Sandra MacDonald, V.O.N. Liaison, Victoria General Hospital

Brian Taylor, Discharge Monitoring, Victoria General Hospital

Shirley White, Discharge Monitoring, Victoria General Hospital

Eleanor Carter, Director Medical Nursing, Victoria General Hospital

Mary Ellen Garnhum, A/Director Surgical Nursing, Victoria General Hospital

Susan MacNeill, Diaylsis Home Care Coordinator, Victoria General Hospital

Dr. Tom Marrie, Acting Chief of Medicine, Victoria General Hospital

Dr. Robert Fraser, Chief of Gynecology, Victoria General Hospital

Pat Cassels, Booking Clerk - Cardiology, Victoria General Hospital

Vina Moses, Booking Clerk - Urology, Victoria General Hospital

Joan Legge, Transplant Unit, Victoria General Hospital

Dorothy Aitken, Head Nurse, 5A, Victoria General Hospital

Carol Donovan, Head Nurse, 5B, Victoria General Hospital

Karen Mumford, Head Nurse, 4 North, Victoria General Hospital

Katherine Allen, Head Nurse, 5 Victoria, Victoria General Hospital

Jean Novitsky, Head Nurse, 5 South, Victoria General Hospital

Dr. K.J. MacKinnon, Medical Director, Halifax Infirmary

Maura Davies, Medical Administrative Coordinator, Halifax Infirmary

Anna Keay, Assistant Director Nursing, Halifax Infirmary

Marilyn MacDonald, DIrector of Social Work, Halifax Infirmary

Bernice Richard, Director Admissions, Registrations, Halifax Infirmary

Christine Rodney, Liaison Coordinator, Halifax Infirmary

Dr. Zitner, Research, Utilization Committee, Halifax Infirmary

Nancy McCara, Head Nurse, Halifax Infirmary

Dr. R.T. Tanton, Internal Medicine, Halifax Infirmary

Salina Richards, Head Nurse, Halifax Infirmary

Peggy Gorman, Head Nurse, Halifax Infirmary

Dr. Nuala Kenny, Medical Director, Izaak Walton Killam

Sharon Jeans, Director of Admissions, Izaak Walton Killam

Sonia Franklin, Director of Nursing, Izaak Walton Killam

Linda Smith, Director of Social Work, Izaak Walton Killam

Mary Catherine McDonnell, Social Work, Izaak Walton Killam

Linda Weaver, Bio-Medical Engineering, Izaak Walton Killam

Dr. Gillis, Chief of Surgery, Izaak Walton Killam

Dr. Eli Reese, Neonatology, Izaak Walton Killam

Pat Summers, Cystic Fibrosis Clinic, Izaak Walton Killam

Susan Langille, Community Care Nurse, Izaak Walton Killam

Eleanor Lindsay, Home Care Coordinator, Izaak Walton Killam

Donna Richards, Assistant Director Ambulatory Care, Izaak Walton Killam

Becky Attenborough, Neonatal Head Nurse, Izaak Walton Killam

Sharon Sinott, 5 East Head Nurse, Izaak Walton Killam

Joan Murray, Neo-Natal Head Nurse, Grace Maternity

Jim Bird, Financial Management, Grace Maternity

Thalia Demano, Director of Nursing, N.S. Rehabilitation Centre

Marg Boak, Director of Surgical Nursing, Camphill Hospital

Shirley Wall, Director of Nursing, Halifax Civic Hospital

Dr. Ginette Gagne-Koch, Medical Director, Moncton Hospital

Sharon Dunphy, Director of Admissions, Moncton Hospital

Marilyn Babineau, Head Nurse, Neurosurgery, Moncton Hospital

Catherine Hope, Discharge Planning, Moncton Hospital

Eileen Borden, Ronald MacDonald House Manager, Halifax, Nova Scotia

Presentations were made to:

1. Clinical Department Heads - Victoria General
2. Social Work Department - Victoria General
3. Social Work Department - Halifax Infirmary

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HOSPITAL SERVICES
COMMISSION

HEALTH SERVICES
COMMISSION

P. O. BOX 4800
CHARLOTTETOWN, P. E. I.
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OUT OF PROVINCE LIAISON PILOT STUDY PROJECT
CONSENT FORM

To be signed at time of Admission

The Prince Edward Island Hospital and Health Services Commission is currently undertaking a pilot study project to identify issues and concerns related to out-of-province patient useage. The unit/specialty to which your child is being admitted is participating in this project.

The intent of the project is to follow all P.E.I. patients on the designated unit/specialty within each hospital from the time of admission until discharged home and document any problems that are obstacles to discharge planning.

This information will assist the P.E.I. Hospital and Health Services Commission to develop recommendations that will provide support for P.E.I. residents who are in hospital out of province in the future.

During the course of your child's hospital stay or when he/she goes home, a P.E.I. Hospital and Health Services Representative will contact you and your physician for comments pertaining to situations where the system can be improved.

Should it be deemed appropriate by your attending physician in the Izaak Walton Killam Children's Hospital for your son/daughter to convalesce in hospital back in P.E.I. close to your family, the P.E.I. Commission will pay the portion of his/her cost for transportation back to an Island Hospital. **THIS PAYMENT SUBSIDY IS FOR HOSPITAL TO HOSPITAL TRANSFERS ONLY FROM OUT OF PROVINCE TO P.E.I. THERE IS NO SUBSIDY FOR HOSPITAL TO HOME.**

This transportation subsidy is in effect only for the duration of the project.

I, , have read the above information and hereby give my permission for to participate in the P.E.I. Hospital and Health Services Out-of-Province Liaison Pilot Study Project allowing information about my child's hospital stay to be documented for the purposes of the pilot study project.

Signature of Parent/ Legal Guardian	Date (mm/dd/yy)	Witness

PERMANENT RECORD

HOSPITAL SERVICES
COMMISSION

HEALTH SERVICES
COMMISSION

P. O. BOX 4800
CHARLOTTETOWN, P. E. I.
C1A 7P4

OUT-OF-PROVINCE LIAISON PILOT STUDY PROJECT
CONSENT FORM

To be signed at time of Admission

The Prince Edward Island Hospital & Health Services Commission is currently undertaking a pilot study project to identify issues and concerns related to out-of-province patient usage. The unit/specialty to which you are being admitted is participating in this project.

The intent of the project is to follow all P.E.I. patients on the designated unit/specialty within each hospital from the time of admission until discharged home and document any problems that are obstacles to discharge planning.

This information will assist the P.E.I. Hospital and Health Services Commission to develop recommendations that will provide support for P.E.I. residents who are in hospital out-of-province in the future.

During the course of your hospital stay or when you go home, a P.E.I. Hospital and Health Services Representative will contact you and your physician for comments pertaining to situations where the system can be improved.

Should it be deemed appropriate by your attending physician in the Hospital; for you to convalesce in hospital back in P.E.I. close to your family; the P.E.I. Commission will pay the portion of your cost for transportation back to an Island Hospital. This payment subsidy is for hospital to hospital transfers only from out-of-province to P.E.I. There is no subsidy for hospital to home.

This transportation subsidy is in effect only for the duration of the project.

I , have read the above information and hereby agree to participate in the P.E.I. Hospital and Health Services Out-Of-Province Liaison Pilot Study Project allowing information about my hospital stay to be documented for the purposes of the pilot study project.

Signature	Date	Witness

BLUE CROSS

ASSIGNMENT OF PAYMENT

I, _____ hereby authorize my benefits payable for the attached out-of-province ambulance claim (receipt) dated _____ to be payable directly to PEI Hospital & Health Services Commission. I understand that the ambulance charge may not be covered by or exceed my policy benefits. I authorize the release of the information contained in this claim to Blue Cross and PEI Hospital & Health Services Commission.

_____ _____

Signature of Subscriber Witness

_____

Date

Blue Cross Contract Number: _____

Blue Cross Group Number: _____

PRINCE EDWARD ISLAND HOSPITAL & HEALTH SERVICES COMMISSION
TRANSPORTATION SUBSIDY PROGRAM OUT-OF-PROVINCE LIAISON PROJECT
Guidelines For Pilot Project

The following criteria applies for a P.E.I. Resident who is an in-patient in an out-of-province hospital to be eligible for subsidization of payment for interhospital transfers.

1) Patient is a resident of P.E.I. and eligible for insured benefits under the P.E.I. Hospital & Health Services Act.
2) The request form for authorization of payment has been completed in the appropriate spaces with the attending physician of the discharging hospital's signature indicating the need for the requested means of transport.
3) Only the portion of the patient's cost of transport that is not already covered by another insurance or Social Assistance program will be paid.
4) This plan applies to in-patients only and is for transfers back to P.E.I. hospitals.
5) P.E.I. ambulance companies are to be used for ambulance services with twenty-four hour prior notification. The exception will be for air transfer where an ambulance is required to deliver a patient to the airport from an out-of-province hospital.
6) The Transportation Subsidy is restricted to the duration of the out-of-province pilot/study project.
7) The patient is to designate the ambulance company to be used for the transfer.

Instructions For Form

These instructions are for the use of the "Request for Transportation Subsidy" Form and are in addition to current policies and guidelines of participating hospitals and/or agencies.

1) Request form must be signed by attending physician.
2) The request form must be sent with the patient to be completed by ambulance company and forwarded to the P.E.I. Hospital & Health Commission along with the bill for the patient's portion of the cost for the service.
3) For air transfers where arrangements have been made for payment of cost prior to the transfer, hospitals/agencies are asked to submit bills along with the request form.
4) Facilities or agencies involved in billing are to ensure that the application for payment form is complete with patient insurance numbers, etc.
5) Only those costs normally charged directly to the patient are to be billed to the P.E.I. Commission. In other words, organizations such as D.V.A., W.C.B. and Social Assistance, who generally pay 100% of the cost with no financial payment required first by the patient are to be billed directly under present conditions.

REQUEST FOR TRANSPORTATION SUBSIDY
PRINCE EDWARD ISLAND RESIDENTS

Hospital & Health Services Commission
PO Box 4500
Charlottetown, PE
C1A 7P4

ADDRESSOGRAPH

This form to accompany patient and be forwarded with bill for payment.

To be completed by Releasing Hospital

Patient Name_____

Releasing Hospital_____ Room #_____

Receiving Hospital_____

Doctor Whom Pat. is referred_____ Tel #_____

Family Physician_____ Date of Transport_____

Mode of Transport ___Ambulance ___Air ___Other

Date Transport Requested_____ Time_____

Diagnosis_____

Special Instructions:

	Yes	No
If Air Travel, have arrangements been made?		
Is availability of bed in receiving hospital verified?		
Has verbal approval for payment been received from PEI?		
Is a nurse required?(RN must escort if I/V or medication		
Is oxygen required?		

I, the undersigned Physician, hereby certify that the above named patient requires transportation by ___Ambulance, ___Air, ___Other for admission to the _____ Hospital, P.E.I.

Physician_____ Date_____

To be completed by Billing Agency

Name of Transport Co._____

Date of Transport_____ Time Left_____ Arrived_____

Insurance #:_____Blue Cross _____GSMIP _____Other

Signature of Nurse_____ Date_____

Signature of Ambulance Operator_____ Date_____